

MEDICAL HISTORY

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:

	YES	NO		YES	NO		YES	NO
HEART MURMUR*	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SMOKE	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC REACTION (HIVES / SWELLING) TO:		
MITRAL VALVE PROLAPSE*	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE DEFECT*	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>	ERYTHROMYCIN	<input type="checkbox"/>	<input type="checkbox"/>
HEART VALVE REPLACEMENT*	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	SULFA	<input type="checkbox"/>	<input type="checkbox"/>
ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	CODEINE	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	OTHER LUNG/BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	LATEX	<input type="checkbox"/>	<input type="checkbox"/>
BYPASS	<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY IN HEALING	<input type="checkbox"/>	<input type="checkbox"/>	LOCAL ANESTHETIC (NOVOCAIN)	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES TO OTHER MEDICATIONS OR SUBSTANCES? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____		
RHEUMATIC FEVER*	<input type="checkbox"/>	<input type="checkbox"/>	ADRENAL/PITUITARY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____		
ARTIFICIAL JOINT (HIP / KNEE)*	<input type="checkbox"/>	<input type="checkbox"/>	LIVER PROBLEMS / DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>			
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS / JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	CANCER / TUMOR	<input type="checkbox"/>	<input type="checkbox"/>
LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS / DYSFUNCTION	<input type="checkbox"/>	<input type="checkbox"/>	OTHER GROWTHS	<input type="checkbox"/>	<input type="checkbox"/>
ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH TROUBLE / ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY / RADIATION THERAPY	<input type="checkbox"/>	<input type="checkbox"/>
HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS OR MENTAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
SICKLE CELL TRAIT	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	OTHER INFECTIOUS DISEASES	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
OTHER BLOOD DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>

*DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL APPOINTMENTS? YES NO DON'T KNOW NAME OF ANTIBIOTIC: _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS, PILLS, OR TONICS? YES NO NAME: _____ FOR: _____
 (I.E., BLOOD PRESSURE, BIRTH CONTROL, STEROIDS, HORMONES) _____ FOR: _____
 _____ FOR: _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO WHY? _____
 PHYSICIAN'S NAME AND PHONE: _____

IS THERE ANY MEDICAL CONDITION OR HEALTH PROBLEM THAT HAS NOT BEEN NOTED ABOVE? YES NO EXPLAIN: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE DENTIST OF ANY CHANGES IN MY HEALTH STATUS OR MY MEDICATIONS. _____ DATE PATIENT / GUARDIAN SIGNATURE _____ DOCTOR / HYGIENIST SIGNATURE _____

INITIAL REVIEW OF PATIENT MEDICAL HISTORY	INTERVIEWER NOTES
MEDICAL ALERT RECOMMENDED: <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
PREMEDICATION RECOMMENDED: <input type="checkbox"/> YES <input type="checkbox"/> NO	_____

YEARLY REVIEW OF PATIENT MEDICAL HISTORY			DATE	PATIENT / GUARDIAN SIGNATURE	DOCTOR / HYGIENIST SIGNATURE
NO CHANGE	CHANGE	LIST:			
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____